

Physician's Certification for Catastrophic Leave Request - Employee

The State of Nevada's Catastrophic Leave program allows State employees to donate excess sick or annual leave to eligible co-workers who have experienced a catastrophe and have exhausted their own paid leave balances. As per NAC 284.576, the following form must be completed in order to substantiate the need for leave.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Section I (to be completed by the employee):

Employee name: _____ Employee ID#: _____

Employee signature: _____ Date: _____

Section II (to be completed by the attending health care provider):

1. Describe the serious illness or accident which supports the need for leave. If your patient experienced an accident, describe the medical conditions that resulted from that accident.

a. What is the date the serious illness commenced or the accident occurred? _____

2. Is your patient's serious illness or medical condition "life threatening" resulting in a substantial risk of death? ☐ No ☐ Yes

a. If yes, please explain. _____

3. Does your patient have a serious illness or medical condition requiring a convalescence which you expect to exceed 10 consecutive weeks? ☐ No ☐ Yes

a. If yes, please explain. _____

4. What is the first date when your patient will need to be absent from work due to a serious illness or accident? _____

5. What is the first date when your patient will be able to return to work? _____

6. Will your patient need follow-up treatment once he/she returns to work? ☐ No ☐ Yes

a. If yes, what is the nature of the follow-up treatment? _____

b. If yes, how frequently will it be required? _____

c. If yes, when do you expect your patient to complete his/her follow-up treatment (date or length of time)?

Health care provider name: _____

Type of practice – field of specialty: _____

Address: _____

Telephone number: _____

Signature of health care provider: _____

Date: _____